Complete Summary

GUIDELINE TITLE

Clinical management of alcohol use and abuse in HIV-infected patients.

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Clinical management of alcohol use and abuse in HIV-infected patients. New York (NY): New York State Department of Health; 2008 Apr. 15 p. [41 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Human immunodeficiency virus (HIV) infection
- Alcohol misuse
- Alcohol withdrawal symptoms

GUIDELINE CATEGORY

Counseling
Diagnosis
Evaluation
Management
Screening
Treatment

CLINICAL SPECIALTY

Allergy and Immunology
Family Practice
Infectious Diseases
Internal Medicine

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Nurses
Physician Assistants
Physicians
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

To focus on the identification and outpatient management of alcohol use and abuse among human immunodeficiency virus (HIV)-infected patients who are engaged in HIV care

TARGET POPULATION

Human immunodeficiency virus (HIV)-infected outpatients who abuse alcohol

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Evaluation/Screening

1. Screening human immunodeficiency virus (HIV)-infected patients for alcohol misuse to assess quantity and frequency of alcohol use
2. Assessing for physical signs and laboratory markers indicative of possible alcohol abuse (e.g., hypertension, resting tachycardia, puffy faces, hepatomegaly, elevated mean cell volume, etc.)
3. Routinely asking about alcohol consumption when assessing adherence to highly active antiretroviral therapy (HAART)

Counseling/Management/Treatment

1. Discussing behavioral risk-reduction measures (e.g., use of barrier protection)
2. Educating patients co-infected with HIV and hepatitis C virus (HCV) regarding the effects of alcohol on the course of HCV infection, advising to abstain from alcohol during HCV antiviral therapy, cautioning patients regarding toxicities from the overlapping effects of alcohol use, HAART and HIV infection
3. Conducting brief interventions including the following topics: risks commonly associated with alcohol use, benefits of abstaining from or reducing alcohol use, referrals to other services
4. Treatment of alcohol withdrawal symptoms using nonpharmacologic therapy or benzodiazepines

5. Referring patients to treatment programs, inpatient treatment or addiction specialists if indicated
6. Adjunctive pharmacological treatment with naltrexone, disulfiram, or acamprosate
7. Follow-up to monitor alcohol use, review goals and progress, and manage relapses

MAJOR OUTCOMES CONSIDERED

- Risks of alcohol intake
- Effectiveness of treatment in reducing alcohol use

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

AIDS Institute clinical guidelines are developed by distinguished committees of clinicians and others with extensive experience providing care to people with human immunodeficiency virus (HIV) infection. Committees* meet regularly to assess current recommendations and to write and update guidelines in accordance with newly emerging clinical and research developments.

The Committees* rely on evidence to the extent possible in formulating recommendations. When data from randomized clinical trials are not available, Committees rely on developing guidelines based on consensus, balancing the use of new information with sound clinical judgment that results in recommendations that are in the best interest of patients.

*Current committees include:

- Medical Care Criteria Committee
- Committee for the Care of Children and Adolescents with HIV Infection
- Dental Standards of Care Committee
- Mental Health Committee
- Women's Health Committee
- Substance Use Committee
- Physician's Prevention Advisory Committee
- Pharmacy Committee

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

All guidelines developed by the Committee are externally peer reviewed by at least two experts in that particular area of patient care, which ensures depth and quality of the guidelines.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Key Point:

The role of the primary care clinician in the management of the patient who abuses alcohol or is dependent on alcohol is as follows:

- Identify the problem
- Present the diagnosis
- Work to engage and motivate the patient
- Participate in the initiation of treatment and continuum of care

Identifying Alcohol Use and Abuse in Human Immunodeficiency Virus (HIV)-Infected Patients

Screening for Alcohol Use

Clinicians should screen all HIV-infected patients for alcohol use at baseline and at least annually. Screening methods should assess quantity and frequency of alcohol use as well as per-occasion amounts to identify binge drinking. If the results are positive, a more detailed screening tool such as the full AUDIT or CAGE should be administered (see Appendix II in the original guideline document).

For at-risk or hazardous drinkers, clinicians should evaluate alcohol use more frequently in order to identify the escalation of present drinking levels or the occurrence of harmful consequences from drinking.

Screening tests should not be performed when patients are under the influence of alcohol.

Clinicians should stress the confidential nature of discussions regarding alcohol use to encourage patients to be open and honest.

Refer to Table 1 in the original guideline document for definitions of terms "at-risk drinking", "hazardous drinking", "alcohol abuse", "alcohol dependence", and "binge drinking" used to describe alcohol misuse.

Clinical Indicators of Alcohol Use

Clinicians should consider alcohol misuse in the differential diagnosis of certain medical disorders that may be alcohol-induced, such as elevated liver enzymes, hypertension, seizures, gastrointestinal bleeding, cognitive impairment, and depression. The presence of clinical indicators should prompt a screen for alcohol use.

Key Point:

Frequent falls or accidents, hypertension that is difficult to treat, and problems at home or at work may be indicative of alcohol-related problems.

Effects of Alcohol Use in HIV-Infected Patients

Alcohol and Adherence

Clinicians should routinely ask about alcohol consumption when assessing adherence to highly active antiretroviral therapy (HAART).

Alcohol and Safer Sex Practices

Clinicians should discuss behavioral risk-reduction measures on a routine and ongoing basis with patients who consume alcohol. These discussions should include use of barrier protection, how to speak with partners about safer sex, and the circumstances under which high-risk sexual behavior might occur.

Alcohol and Hepatitis C Virus (HCV)

Clinicians should educate HIV/HCV co-infected patients regarding the effects of alcohol on the course of HCV infection. Patients who have other underlying liver disease should be advised to abstain from alcohol.

Clinicians should advise patients to abstain from alcohol during HCV antiviral therapy. Patients with alcohol abuse or dependence should be encouraged to enroll in a rehabilitation program and establish abstinence prior to HCV antiviral treatment.

Provider Assistance, Counseling, and Brief Interventions

Clinicians should:

- Conduct brief interventions with patients who are at-risk drinkers
- Use brief interventions to help motivate patients who meet diagnostic criteria for an alcohol use disorder (abuse and/or dependence) but decline referral for care
- Use nonjudgmental language when counseling patients who use alcohol

When brief interventions are not successful in motivating change, the clinician should refer the patient for further assessment and treatment from an addiction specialist.

Referral for Treatment

Clinicians should refer patients:

- With active alcohol use/abuse problems to treatment programs
- With alcohol abuse or dependence who are not willing to cut down on their alcohol consumption for further assessment and treatment by professional alcohol treatment services
- Who require more intensive management for alcohol withdrawal to inpatient treatment or to addiction specialists

Key Point:

Clinicians should be familiar with the resources available in the community for alcohol treatment programs and services. Sources of care can be found on the Office of Alcoholism and Substance Abuse Services website.

Table 3 in the original guideline document shows the various alcohol treatment referral options that are available for patients who abuse or are dependent on alcohol.

Treatment for Alcohol Withdrawal

Clinicians should use nonpharmacologic therapy or benzodiazepines to manage patients with mild or moderate alcohol withdrawal symptoms.

Clinicians should hospitalize patients with a history of severe alcohol withdrawal symptoms for medical management.

Pharmacologic Management of Alcohol Abuse

Clinicians should determine the benefit of pharmacotherapy with naltrexone, disulfiram, or acamprosate for the treatment of alcohol use disorders on a case-by-case basis. Pharmacotherapy should be used as an adjunct to behavioral therapy.

Clinicians should avoid naltrexone in patients with acute hepatitis or liver failure.

Refer to Table 4 in the original guideline document for information on adjunctive pharmacological agents such as disulfiram, naltrexone, and acamprosate for the treatment of alcohol misuse.

Follow-Up

At-Risk or Hazardous Drinkers

Clinicians should:

- Review goals, progress, and laboratory results (when applicable) with the patient during each follow-up appointment
- Assess the patient's motivation for change
- Reinforce safe drinking levels
- Actively support patient efforts to reduce alcohol use

Patients Receiving Treatment for Alcohol Use

Clinicians should:

- Arrange follow-up appointments to monitor the patient's alcohol consumption and progress

- Provide supportive feedback to patients who are engaged in a recovery program
- Ask patients about the date of last use of alcohol at every monitoring visit to identify relapses
- Inform patients that relapse is common and part of the therapeutic process
- Assess the patient's continued motivation for further change, when applicable

Key Point:

Sustained behavior change is often accomplished gradually. Relapse should be recognized as part of the usual clinical course of alcohol abuse.

Relapse of Alcohol Use

Clinicians should:

- Anticipate relapses
- Adopt a nonjudgmental attitude toward the patient's resumption of alcohol use when/if it occurs
- Encourage participation in treatment

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate identification and management of alcohol use and abuse in human immunodeficiency virus (HIV)-infected patients

POTENTIAL HARMS

Adverse effects of *naltrexone* include nausea, headache, arthralgias, anxiety, and sedation

CONTRAINDICATIONS

CONTRAINDICATIONS

- Contraindications to *disulfiram* include concomitant use of alcohol or alcohol-containing preparations.
- *Naltrexone* is contraindicated in patients currently using opioids or in acute opioid withdrawal (patients who use opioids should be opioid-free for 3 to 4 days before initiating naltrexone) and patients with acute hepatitis or liver failure.
- *Acamprosate* is contraindicated in severe renal impairment (creatinine clearance [CrCl] $\leq$30mL/min).

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The AIDS Institute's Office of the Medical Director directly oversees the development, publication, dissemination and implementation of clinical practice guidelines, in collaboration with The Johns Hopkins University, Division of Infectious Diseases. These guidelines address the medical management of adults, adolescents and children with human immunodeficiency virus (HIV) infection; primary and secondary prevention in medical settings; and include informational brochures for care providers and the public.

Guidelines Dissemination

Guidelines are disseminated to clinicians, support service providers and consumers through mass mailings and numerous AIDS Institute-sponsored educational programs. Distribution methods include the HIV Clinical Resource website, the Clinical Education Initiative, the AIDS Educational Training Centers (AETC) and the HIV/AIDS Materials Initiative. Printed copies of clinical guidelines are available for order from the New York State Department of Health (NYSDOH) Distribution Center for providers who lack internet access.

Guidelines Implementation

The HIV Clinical Guidelines Program works with other programs in the AIDS Institute to promote adoption of guidelines. Clinicians, for example, are targeted through the Clinical Education Initiative (CEI) and the AETC. The CEI provides tailored educational programming on site for health care providers on important topics in HIV care, including those addressed by the HIV Clinical Guidelines Program. The AETC provides conferences, grand rounds and other programs that cover topics contained in AIDS Institute guidelines.

Support service providers are targeted through the HIV Education and Training initiative which provides training on important HIV topics to non-physician health and human services providers. Education is carried out across the State as well as through video conferencing and audio conferencing.

The HIV Clinical Guidelines Program also works in a coordinated manner with the HIV Quality of Care Program to promote implementation of HIV guidelines in New York State. By developing quality indicators based on the guidelines, the AIDS Institute has created a mechanism for measurement of performance that allows

providers and consumers to know to what extent specific guidelines have been implemented.

Finally, best practices booklets are developed through the HIV Clinical Guidelines Program. These contain practical solutions to common problems related to access, delivery or coordination of care, in an effort to ensure that HIV guidelines are implemented and that patients receive the highest level of HIV care possible.

IMPLEMENTATION TOOLS

Personal Digital Assistant (PDA) Downloads

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Clinical management of alcohol use and abuse in HIV-infected patients. New York (NY): New York State Department of Health; 2008 Apr. 15 p. [41 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008 Apr

GUIDELINE DEVELOPER(S)

New York State Department of Health - State/Local Government Agency [U.S.]

SOURCE(S) OF FUNDING

New York State Department of Health

GUIDELINE COMMITTEE

Substance Abuse Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Chair: Marc N Gourevitch, MD, MPH, New York, University School of Medicine, New York, New York

Committee Members: Bruce D Agins, MD, MPH, New York State Department of Health AIDS Institute, New York, New York; Julia H Arnsten, MD, MPH, Montefiore Medical Center, Bronx, New York; Lawrence S Brown, Jr, MD, MPH, FASAM, Addiction Research and Treatment Corporation, Brooklyn, New York; Brenda Chabon, PhD, Montefiore Medical Center, Bronx, New York; Barbara H Chaffee, MD, MPH, Binghamton Family Care Center, Binghamton, New York; Michael L Christie, MD, AIDS Community Health Center, Rochester, New York; Chinazo O Cunningham, MD, Montefiore Medical Center, Bronx, New York; Nereida L Ferran-Hansard, MD, Jacobi Medical Center, Bronx, New York; Steven S Kipnis, MD, FACP, FASAM, New York State Office of Alcoholism and Substance Abuse Services, Orangeburg, New York; Joseph P Merlino, MD, MPA, Mount Sinai School of Medicine, New York, New York; Nancy Murphy, NP, St. Luke's Roosevelt Hospital Center, New York, New York; Edward Nunes, MD, New York State Psychiatric Institute, New York, New York; David C Perlman, MD, Beth Israel Medical Center, New York, New York; Sharon L Stancliff, MD, Harm Reduction Coalition, New York, New York; Robert Whitney, MD, Erie County Medical Center, Buffalo, New York

Liaisons: Daliah I Heller, MPH, Liaison to the New York City Department of Health and Mental Hygiene, New York, New York

AIDS Institute Staff Liaisons: Diane M Rudnick, MEd, Liaison to the New York State Department of Health AIDS Institute, New York, New York

AIDS Institute Staff Physician: Eunmee H Chun, MD, New York State Department of Health AIDS Institute, New York, New York

Principal Contributor: Joseph Conigliaro, MD, MPH, VA Pittsburgh Healthcare System, and the University of Pittsburgh School of Medicine, Pittsburgh

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.

AVAILABILITY OF COMPANION DOCUMENTS

This guideline is available as a Personal Digital Assistant (PDA) download from the New York State Department of Health AIDS Institute Web site.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on July 3, 2008.

COPYRIGHT STATEMENT

DISCLAIMER

NGC DISCLAIMER

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at http://www.guideline.gov/about/inclusion.aspx .

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.

Date Modified: 9/15/2008